This packet is an example of the order in which documents should be filed. These are not examples of how to fill out forms/documents.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

Is this a new case? Yes ☐ No ☑ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☐

More than 15 Companion Cases ☐

09/10/2008
Date:(MM/DD/YYYY)

SSN: 000-00-0000

VOC12345
Case Number 1

☐ Specific Injury
☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

Please check unit to be filed on (check only one box)

☐ ADJ ☐ DEU ☐ SIF ☐ UEF ☑ VOC ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

_____
Case Number 2

☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

DOCUMENT SEPARATOR SHEET

Product Delivery Unit VOC

Document Type DWC - REHAB FORMS

Document Title RU-103 REQUEST FOR DISPUTE RESOLUTION

Date of document following Document Separator Sheet

Document Date _____
MM/DD/YYYY

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Author UNIFORM ASSIGNED NAME

Office Use Only

Received Date _____
MM/DD/YYYY

DWC-CA form 10232.2

Request for Dispute Resolution

___Original ___Response

Has employer accepted this claim?
___ Yes ___ No
Has liability for injury been found by the WCAB?
___ Yes ___ No
Has more than 90 days of TTD been paid?
___ Yes ___ No

Rehabilitation Use Only

Social Security Number	WCAB Number	Rehab Unit Number

Employee Name (Last) (First) (MI) Date of Birth

Address (Street) (City) (State) (Zip)

Employer Name	Insurance Company Name; Or, if Self-Insured, Certificate Name
Address	Adjusting Agency Name (if adjusted)
City, State, Zip	Claims Mailing Address
Date of Injury / Claim Number	City, State, Zip Phone No.

Employee Representative	Employer Representative
Firm Name	Firm Name
Address	Address
City, State, Zip Phone No.	City, State, Zip Phone No.

Qualified Rehabilitation Representative

Firm Name Representative Name

Address (Street, City, State, Zip Phone No.

The Rehabilitation Unit is requested to resolve the following dispute on an expedited basis because the parties disagree on : (Check the single issue which applies)

___ The identification of a vocational goal (for injuries after 1/1/94)
___ The selection of a Independent Vocational Evaluator
___The description of the employee's job duties at the time of injury (for injuries after 1/1/94)
___The employee objects to the attached Notice of Intent to Withhold Maintenance Allowance

Non-Expedited Issues: (Check the issue(s) that apply)

___ The employee objects to a Notice of Termination
___ The employee's medical eligibility for vocational rehabilitation services. Medical report relied upon by requester:_____
___ The employer has failed to provide vocational rehabilitation services and benefits. My QRR preference is: (if any)_____
On what date should the employer have provided vocational rehabilitation services? _____ / _____ / _____ (Attach explanation)
Date last worked _____ / _____ / _____ Date of last temporary disability _____ / _____ / _____
___ The employee requested reinstatement and the employer failed to respond. On what date was request made to claims administrator? _____ / _____ / _____
How does the employee substantiate this request? [Attach supporting document(s)]
___ This is in response to a previously submitted RU-103 dated _____ / _____ / _____
___ Other disputed issues (please describe the nature):

Summary of Parties' Informal Efforts to Resolve this Dispute

An informal conference was held on _____. A summary of the conference, including a list of attendees, issues addressed, agreements reached and other unresolved issues is attached. If an informal conference was not held, attach explanation.

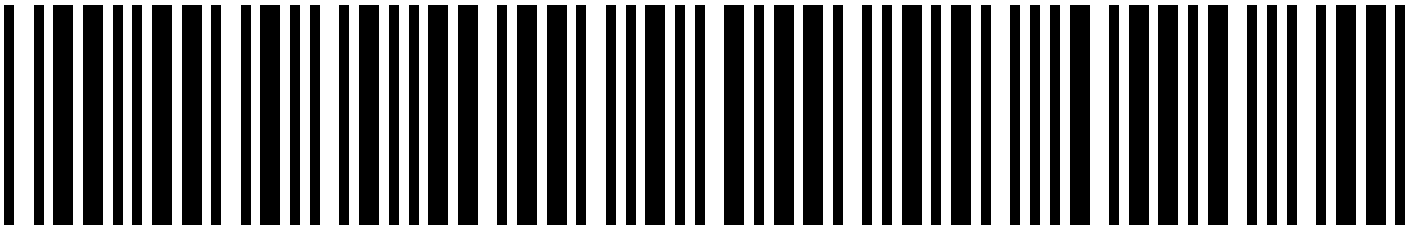
Copies of this request with copies of medical and vocational reports have been served on:

Name of Requester	Date	Signature

(Voc. Rehab.) §10133.14

Mandatory Format
State of California
DWC Form RU-103 (01/03)

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: VOC

Document Type: SUPPORTING DOCUMENTS

Document Title: POSITION STATEMENT

Document Date: 06/05/2008
MM/DD/YYYY

Author: UNIFORM ASSIGNED NAME

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Office Use Only

Received Date
MM/DD/YYYY

DWC-CA form 10232.2

Statement Dated June 5, 2008

Position Statement authored by
Claims Administrator,
Hearing Representative or
an Unrepresented Injured Worker.

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: VOC

Document Type: SUPPORTING DOCUMENTS

Document Title: MEDICAL REPORT

Document Date: 06/05/2008
MM/DD/YYYY

Author: JOHN A SMITH MD

Office Use Only

Received Date
MM/DD/YYYY

DWC-CA form 10232.2

DR. JOHN A. SMITH MEDICAL REPORT

REPORT DATED June 5, 2008

DOCUMENT SEPARATOR SHEET

Product Delivery Unit VOC

Document Type SUPPORTING DOCUMENTS

Document Title RU-120 INITIAL EVALUATION SUMMARY

Date of document following Document Separator Sheet

Document Date _____
MM/DD/YYYY

Author QRR NAME

Office Use Only

Received Date _____
MM/DD/YYYY

DWC-CA form 10232.2

INITIAL EVALUATION SUMMARY

Claims Administrator:	Employee:	
Address:	Claim #:	DOI:
City/State/Zip:	Employer:	
Contact Name:	Date of Initial Evaluation:	

Reason for Referral:

_____Full Service _____Evaluation Only

Initial Meeting and Impressions: Vocationally Feasible? ____Yes ____No ____Deferred (Explain)

Summary:

Recommendations:

Plan of Action:

Next Reporting Date:

QRR (Print Name): Telephone:	Signature:	Date:

Attachments: a) Data Sheet b) _____ c) _____ d) _____	Copies Sent To: a) _____ b) _____ c) _____ d) _____

INITIAL EVALUATION DATA SHEET

PERSONAL INFORMATION: Name:

Male: Female:	Social Security No.:	DOB:
Phone No.:	CA Driver's License No.:	Exp. Date:

License Restrictions (Explain):

Distance willing to travel to work (one way):	Areas willing to drive:

Reliable vehicle available for transportation (full-time): _____Yes _____No
If no, what method of transportation will be used?:

Willing to relocate? Yes No	Work Shifts: All Days All Shifts M-F Only 8-5 Only

Describe issues which may interfere with employee's participation in services:

SOCIO-FAMILY FINANCIAL HISTORY

Marital status: Married Single Divorced Widowed Separated

Number of Dependents Living at Home:	Ages:	Child Support Payments? ___Yes___No Amount: $
Child care required: Yes No	Estimated amount per week: $	

Able to financially support self throughout duration of services: ___Yes ___No (Explain):

Receiving VRMA? Yes No	Amount per week: $
Receiving PD Supplement? Yes No	Amount per week: $

Other sources of income (explain):

EDUCATIONAL BACKGROUND

High School Graduate? ____Yes ____ No Year:	Name & Location of High School:
If not HS graduate, GED? _____Yes Year: _____ If No GED - Last grade completed:	Post-HS Studies: ___Certificate ___AA/AS ___BA/BS Area of Study: Year:

English Language Speak ___Yes___No Read ___Yes___No Level _____ Write ___Yes___No Level _____	Other Language: _____ Speak _____Yes _____ No Read _____Yes _____ No Write _____Yes _____ No

Employee's List of Perceived Work Skills:

MILITARY SERVICE: Dates of Service: Branch:

Special Skills:

VOCATIONAL HISTORY

Company, Location	Dates Employed From	To	Job Title	Salary	Reason for Leaving

MEDICAL FILE REVIEW

Treating Physician: Phone:

Address:

Medical Restrictions:

Permanent & Stationary	Yes	No	Date:

Medical Restrictions/Limitations (specify medical report and date relied upon):

Current Medications (specify medical report and date relied upon):

Currently in Physical Therapy: _____Yes _____No Days/Times:

Non-Industrially Related Medical Conditions (explain):

PRESENT PHYSICAL TOLERANCES (Subjective)

Sitting _____minutes
Standing _____minutes
Driving _____minutes
Walking _____minutes

Lifting _____ # of Pounds: _____
Climb Steps: Can _____Cannot _____
Bending: Can _____ Cannot _____
Dominant Hand: Rt. _____ Lft. _____

Reaching
Below shoulder _____Yes_____No
At shoulder _____Yes_____No
Handling/Feeling _____Yes_____No
Pushing/Pulling _____Yes_____No

Vision Restriction _____Yes _____No Ready to Return to Work _____Yes_____No

Supplemental Medical/Physical Information:

VOCATIONAL CONSIDERATIONS

Preliminary Assessment of Transferable Skills:

Client's Expressed Interest/Expectations of Vocational Rehabilitation:

Observations (Comments on Appearance, Rapport, Cooperation, Attitude):

VOCATIONAL FEASIBILITY FACTORS

Can the employee reasonably benefit from the provision of vocational rehabilitation services?

INVESTIGATION OF MODIFIED/ALTERNATIVE EMPLOYMENT

	Available	Contact:
	Not Available	Title:
	Unknown/Not Requested	Date of Conduct:

EXPLANATION OF VOCATONAL REHABILITATION PROCESS
(Check Box For All Issues Covered With Employee)

	EE Role		Caps/Limits on VR		Termination Process
	QRR Role		VRMA		Reinstatement Process
	Carrier/ER Role		Dispute Resolution Process		Interruption Process
	Rehab Unit Role		Effect of Delays		Allowable Costs
	Help RTW Brochure		Plan Definition		Nature, Extent Added Costs
	Plan Hierarchy		Plan Parameters		Other (Explain)

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: VOC

Document Type: SUPPORTING DOCUMENTS

Document Title: RU-121 VOC REHAB PROGRESS REPORT

Date of document following Document Separator Sheet

Document Date: _____
MM/DD/YYYY

Author: QRR NAME

Office Use Only

Received Date: _____
MM/DD/YYYY

DWC-CA form 10232.2

VOCATIONAL REHABILITATION PROGRESS REPORT

Claims Administrator:	Employee:	
Address:	Claim #:	DOI:
City/State/Zip:	Employer:	
Contact Name:	Report Date: Period Covered:	
Anticipated Plan Submission Date:	Date Vocational Feasibility:	
Plan Goal:	Plan Start Date:	Plan Completion Date:
Dates of Meetings/Appointments/Classes Attended:	Dates of Missed Meetings/Appointments/Classes:	

Services Provided:

Summary of Activities and Comments:

Recommendations/Plan of Action:

Next Reporting Date:

QRR (Print Name):	Signature:	Date:
Telephone Number:		

Attachments:	Copies Sent To:	VR Initiated Pre 1998	VR Initiated Post 12/31/97
		Phase I: $	Phase A: $
		Phase II: $	
		Phase III: $	Phase B: $
Report Prep Time: mins		Cum. Total: $	Cum. Total: $

DOCUMENT SEPARATOR SHEET

Product Delivery Unit VOC

Document Type SUPPORTING DOCUMENTS

Document Title RU-94 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

Date of document following Document Separator Sheet

Document Date _____
MM/DD/YYYY

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Author UNIFORM ASSIGNED NAME

Office Use Only

Received Date _____
MM/DD/YYYY

NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

THIS SECTION COMPLETED BY EMPLOYER OR CLAIMS ADMINISTRATOR:

Employer (name of firm)_____ is offering you the position of a

(name of job) _____.

Attach a list of the duties required of the position.

You may contact _____ concerning this offer. Phone No.: _____

Date of offer: _____. Date job starts: _____.

Claims Administrator:_____Claim Number:_____

NOTICE TO EMPLOYEE Name of employee: _____

Date offer received: _____

You have 30 calendar days from receipt to accept or reject this offer of modified or alternative work. If you reject this job offer, you will not be entitled to rehabilitation services unless:

Modified Work

A. The proposed modification(s) to accommodate required work restrictions are inadequate.
B. The modified job will not last 12 months.

Alternative Work

A. You cannot perform the essential functions of the job; or
B. The job is not a regular position lasting at least 12 months; or
C. Wages and compensation offered were less than 85% paid at the time of injury; or
D. The job is beyond a reasonable commuting distance from residence at time of injury.

THIS SECTION TO BE COMPLETED BY EMPLOYEE

☐ I accept this offer of Modified or Alternative work.

☐ I reject this offer of Modified or Alternative work and understand that I am not entitled to vocational rehabilitation services.

_____ Date _____

Signature

I feel I cannot accept this offer because:

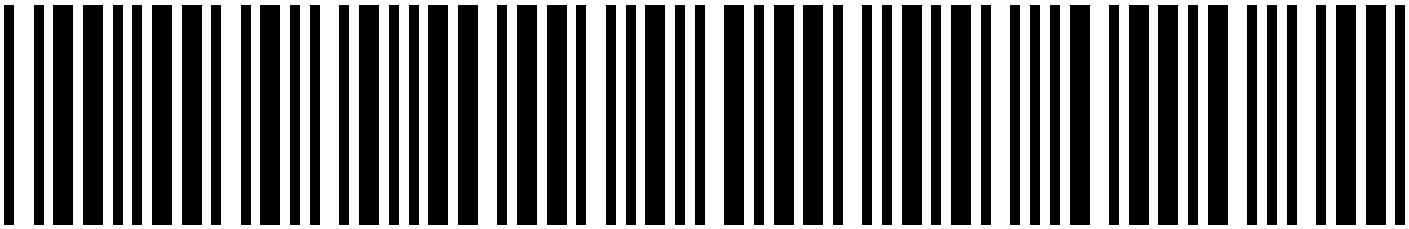
NOTICE TO THE PARTIES

If the offer is <u>not</u> accepted or rejected within 30 days of the offer, the offer is deemed to be rejected by the employee.

The employer or claims administrator must forward a completed copy of this agreement to the Rehabilitation Unit with a Notice of Termination (DWC Form RU-105) within 30 days of acceptance or rejection.
If a dispute occurs regarding the above offer or agreement, either party may request the Rehabilitation Unit to resolve the dispute by filing a Request for Dispute Resolution (DWC Form RU-103) at the applicable Rehabilitation Unit. The Rehabilitation Unit venue is the same as the Workers' Compensation Appeals Board. If no WCAB case exists, file with a Rehabilitation Unit at the appropriate district office.

MANDATORY FORMAT
STATE OF CALIFORNIA
DWC-RU-94 (01/03) §10133.12

DOCUMENT SEPARATOR SHEET



Product Delivery Unit VOC

Document Type SUPPORTING DOCUMENTS

Document Title RU-91 DESCRIPTION OF EMPLOYEE'S JOB DUTIES

Date of document following Document Separator Sheet

Document Date _____
MM/DD/YYYY

Author UNIFORM ASSIGNED NAME OR QRR NAME

Office Use Only

Received Date _____
MM/DD/YYYY

DWC-CA form 10232.2

State of California
Division of Workers' Compensation

DESCRIPTION OF EMPLOYEE'S JOB DUTIES

INSTRUCTIONS: This form shall be developed jointly by the employer and employee and is intended to describe the employee's job duties. The completed form will be reviewed by the treating doctor to determine whether the employee is able to return to his/her job. This is an important document and should accurately show the requirements of the employee's job. If the employee needs help in completing this form, the employee may contact the Information and Assistance Officer at the Division of Workers' Compensation. The phone number can be found in the State Government section of the phone book.

EMPLOYEE NAME: (LAST) (FIRST) (M.I.)	CLAIM #:

EMPLOYER NAME:	JOB ADDRESS:

JOB TITLE:	HRS. WORKED PER DAY:	HRS. WORKED PER WEEK:

DESCRIPTION OF JOB RESPONSIBILITIES: (DESCRIBE ALL JOB DUTIES)

1. Check the frequency of activity required of the employee to perform the job.

ACTIVITY (Hours per day)	NEVER 0 hours	OCCASIONALLY up to 3 hours	FREQUENTLY 3–6 hours	CONSTANTLY 6–8+ hours
Sitting				
Walking				
Standing				
Bending (neck)				
Bending (waist)				
Squatting				
Climbing				
Kneeling				
Crawling				
Twisting (neck)				
Twisting (waist)				
Hand Use: Dominant hand Right___ Left___				
Is repetitive use of hand required?				
Simple Grasping (right hand)				
Simple Grasping (left hand)				
Power Grasping (right hand)				
Power Grasping (left hand)				
Fine Manipulation (right hand)				
Fine Manipulation (left hand)				
Pushing & Pulling (right hand)				
Pushing & Pulling (left hand)				
Reaching (above shoulder level)				
Reaching (below shoulder level)				

2. Please indicate the daily Lifting and Carrying requirements of the job:
Indicate the height the object is lifted from floor, table or overhead location and the distance the object is carried.

	LIFTING					CARRYING				
	Never 0 hours	Occasionally up to 3 hours	Frequently 3–6 hours	Constantly 6–8+ hours	Height	Never 0 hours	Occasionally up to 3 hours	Frequently 3–6 hours	Constantly 6–8+ hours	Distance
0–10 lbs.										
11–25 lbs.										
26–50 lbs.										
51–75 lbs.										
76–100 lbs.										
100+ lbs.										

Describe the heaviest item required to carry and the distance to be carried: _____

_____

3. Please indicate if your job requires:

	YES	NO	(IF YES, PLEASE BRIEFLY DESCRIBE)
a. Driving cars, trucks, forklifts and other equipment?	☐	☐	
b. Working around equipment and machinery?	☐	☐	
c. Walking on uneven ground?	☐	☐	
d. Exposure to excessive noise?	☐	☐	
e. Exposure to extremes in temperature, humidity or wetness?	☐	☐	
f. Exposure to dust, gas, fumes, or chemicals?	☐	☐	
g. Working at heights?	☐	☐	
h. Operation of foot controls or repetitive foot movement?	☐	☐	
i. Use of special visual or auditory protective equipment?	☐	☐	
j. Working with bio-hazards such as: bloodborne pathogens, sewage, hospital waste, etc.	☐	☐	

Employee Comments:

Employer Comments:

EMPLOYER CONTACT NAME:	EMPLOYER CONTACT TITLE:
EMPLOYER REPRESENTATIVE SIGNATURE:	DATE:
EMPLOYEE'S SIGNATURE:	DATE:
QUALIFIED REHAB. REPRESENTATIVE SIGNATURE: (IF APPLICABLE)	DATE: